



General

Guideline Title

Practice parameters for the management of perianal abscess and fistula-in-ano.

Bibliographic Source(s)

Steele SR, Kumar R, Feingold DL, Rafferty JL, Buie WD, Standards Practice Task Force of the American Society of Colon and Rectal Surgeons. Practice parameters for the management of perianal abscess and fistula-in-ano. Dis Colon Rectum. 2011 Dec;54(12):1465-74. [129 references] [PubMed](#)

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Whiteford MH, Kilkenny J 3rd, Hyman N, Buie WD, Cohen J, Orsay C, Dunn G, Perry WB, Ellis CN, Rakinic J, Gregorcyk S, Shellito P, Nelson R, Tjandra JJ, Newstead G. Practice parameters for the treatment of perianal abscess and fistula-in-ano (revised). Dis Colon Rectum 2005 Jul;48(7):1337-42. [63 references]

Recommendations

Major Recommendations

The levels of evidence and the grades of recommendations (1A-2C) are defined at the end of the "Major Recommendations" field.

Recommendations

Initial Evaluation of Perianal Abscess and Fistula-in-Ano

1. A disease-specific history and physical examination should be performed, emphasizing symptoms, risk factors, location, and presence of secondary cellulitis or fistula-in-ano. Grade of Recommendation: Strong recommendation based on low-quality evidence 1C
The diagnosis of anorectal abscess is usually made based on the patient's history and physical examination. It is important to distinguish anorectal abscess from other perianal suppurative processes such as hidradenitis suppurativa, infected skin furuncles, and infectious processes including herpes simplex virus, human immunodeficiency virus (HIV), tuberculosis, syphilis, and actinomycosis. In addition, features suggestive of Crohn's disease, including large skin tags or multiple fistulas, require a more detailed workup and potentially additional medical therapy.

On examination, a tender, fluctuant mass is almost always present with perianal and ischiorectal abscesses. Patients with intersphincteric or supralelevator abscesses may have a paucity of external findings, with only pelvic or rectal tenderness or fluctuance on digital rectal examination. Careful inspection may detect the presence of other anorectal pathology or an external opening suggestive of a fistula-in-ano.

Palpation of the perianal area, digital rectal examination, and careful probing of the tract(s) often aids in defining the presence and anatomy of the fistula. Anoscopy and sigmoidoscopy may be performed to try to visualize the internal opening of a fistula and other mucosal abnormalities such as proctitis secondary to Crohn's disease. In general, laboratory evaluation is not necessary, with the exception of patients with systemic symptoms such as fever, serious underlying medical problems, or an unclear diagnosis.

2. Studies such as fistulography, endoanal ultrasound, computed tomography (CT) scan, and magnetic resonance imaging (MRI) may be considered in selected patients to help define the anatomy of an anorectal abscess or fistula-in-ano and to guide management. Grade of Recommendation: Strong recommendation based on low-quality evidence 1C

Although anorectal abscess and fistula-in-ano are most commonly diagnosed and managed on the basis of clinical findings alone, adjunctive radiological studies can occasionally provide valuable information in complex tracts or recurrent disease. The vast majority of fistulas, however, do not require any imaging. Traditionally, fistulography was the method of choice. Reported accuracy rates as low as 16% have largely led to this test falling out of favor. Endoanal ultrasound is very effective for characterizing anorectal abscess and fistulas with accuracy rates as high as 80% to 89% for delineating fistula tracts, and is especially effective in identifying horseshoe abscess extensions. Three-dimensional ultrasound techniques provide even better imaging, especially in patients with complex perianal sepsis or high-riding tracts. Combining 3-dimensional ultrasound with hydrogen peroxide injection through the external opening has demonstrated accuracy rates comparable to MRI, with close to 90% concordance. CT scan can be useful for patients with complex suppurative anorectal conditions, and is especially helpful in identifying supralelevator abscesses, or for those patients who would otherwise be difficult to examine without anesthesia. In patients with Crohn's disease who have perianal pathology, CT has proven reliable in helping to delineate fistulas and abscesses from isolated rectal inflammation.

MRI with or without endoanal coils has reported accuracy rates of more than 90% for mapping fistula tracts and identifying the internal opening. The majority of studies comparing pelvic MRI with endoanal ultrasound have shown slightly higher rather than lower rates of sensitivity and accuracy—depending, in part, on operator experience (ultrasound) and patient population (i.e., recurrent disease, abscess/fistula location, Crohn's disease).

Perianal Abscess

1. Patients with acute anorectal abscess should be treated in a timely fashion with incision and drainage. Grade of Recommendation: Strong recommendation based on low-quality evidence 1C.

The primary treatment of anorectal abscesses remains surgical drainage. In general, the incision should be kept as close as possible to the anal verge to minimize the length of a potential fistula, while still providing adequate drainage. With an adequately sized elliptical incision, postoperative wound packing is usually not necessary. A variation of incision and drainage uses a small latex catheter (e.g., 10–14F Pezzer catheter) placed into the abscess cavity with the use of local anesthesia and a small stab incision. The catheter is removed when the abscess drainage stops and the cavity has closed down around the catheter (usually 3–10 days).

After simple incision and drainage, the overall recurrence rate ranges from 3% to 44%, depending on the abscess location and the length of follow-up. Additional factors associated with recurrence and the need for early repeat drainage include incomplete initial drainage, failure to break up loculations within the abscess, missed abscess, and undiagnosed fistula. Horseshoe abscesses have been associated with especially high rates of persistence and recurrence ranging between 18% and 50% and often require multiple operations before definitive healing.

2. Antibiotics have a limited role in the treatment of uncomplicated anorectal abscess. Grade of Recommendation: Strong recommendation based on moderate-quality evidence 1B.
3. Antibiotics may be considered in patients with significant cellulitis, underlying immunosuppression, or concomitant systemic illness. Grade of Recommendation: Weak recommendation based on low-quality evidence 2C.

In general, the addition of antibiotics to routine incision and drainage of uncomplicated anorectal abscess does not improve healing time or reduce recurrences, and it is therefore not indicated. However, limited data suggest that antibiotics be considered for use in patients with extensive cellulitis, systemic symptoms, or failure to improve with drainage alone. In patients with underlying immunosuppression, the data also suggest that antibiotics may play a role.

The emergence of community-acquired methicillin-resistant *Staphylococcus aureus* in otherwise routine anorectal abscesses raises the question whether wound culture is indicated after incision and drainage. Although wound culture is rarely helpful, it may be considered in cases of recurrent infection or nonhealing wounds. Patients with underlying HIV infection with either concomitant infections or atypical microbes, including tuberculosis may benefit from wound culture and targeted antibiotic treatment.

Finally, recent guidelines from the American Heart Association recommend preoperative antibiotics before incision and drainage of infected tissue in patients with prosthetic valves, previous bacterial endocarditis, congenital heart disease, and heart transplant recipients with valve pathology. Unlike prior guidelines, antibiotic prophylaxis is no longer recommended in patients with routine mitral valve prolapse.

Treatment of a Simple Fistula-in-Ano

1. Simple anal fistulas may be treated by fistulotomy. The addition of marsupialization may improve the rate of wound healing. Grade of Recommendation: Strong recommendation based on moderate-quality evidence 1B.
2. Concomitant fistulotomy with incision and drainage may be considered in select patients with anorectal abscess and fistula. Grade of Recommendation: Weak recommendation based on moderate-quality evidence 2B.
The surgeon should weigh the possible decreased recurrence rate in light of the potential increased risk of continence disturbances.
3. Simple anal fistulas may be treated with debridement and fibrin glue injection. Grade of Recommendation: Weak recommendation based on low-quality evidence 2C.
Fibrin glue has a number of advantages, including its ease of use, repeatability, and avoidance of sphincter division, especially in patients with a high risk of incontinence following fistulotomy. However, this must be weighed against the high failure rate.

Treatment of Complex Fistula-in-Ano

In select patients, radiographic evaluation may be beneficial to identify an occult internal opening and secondary tracts or abscesses, or to help delineate the fistula's relationship to the sphincter complex.

1. Complex anal fistulas may be treated with debridement and fibrin glue injection. Grade of Recommendation: Weak recommendation based on low-quality evidence 2C.
Although fibrin glue therapy has a relatively low success rate in complex disease, for those that eventually heal, it does appear to be a durable repair. Furthermore, given the low morbidity associated with the procedure, it may be considered for initial therapy.
2. Anal fistula plug may be used for treatment of complex anal fistula disease. Grade of Recommendation: Weak recommendation based on moderate-quality evidence 2C.
The bioprosthetic anal fistula plug is used to close the primary internal anal opening and serves as a matrix for the obliteration of the fistula tract. The low morbidity, repeatability, and lack of other options warrant consideration of this therapy in patients with complex fistulas.
3. Endoanal advancement flaps may be used for treatment of complex anal fistula disease. Grade of Recommendation: Strong recommendation based on moderate-quality evidence 1C.
Endoanal advancement flap is another sphincter-sparing technique that consists of curettage of the tract, and mobilizing a segment of proximal healthy anorectal mucosa, submucosa, and muscle to cover the site of the sutured internal opening.
4. Complex anal fistulas may be treated by the use of a seton and/or staged fistulotomy. Grade of Recommendation: Strong recommendation based on moderate-quality evidence 1B.
The seton (i.e., suture, rubber band, Silastic vessel loop) is passed through the fistula tract to convert an inflammatory process to a foreign body reaction causing perisphincteric fibrosis. Setons may be of the cutting type, for which progressive tightening will produce a gradual fistulotomy with scarring of the tract, over the course of weeks. Alternatively, a loose seton may be placed to promote drainage and avoidance of recurrent perineal sepsis, and may be left in place long-term or removed with ultimate cure.

In the setting of complex anal fistulas, setons are commonly used in a staged fashion, with initial seton placement to control sepsis followed by a secondary procedure (i.e., endoanal advancement flap, fibrin glue, anal plug) weeks later to avoid division of the sphincter muscle. Finally, in sepsis secondary to fistula disease that is recalcitrant to other methods, diversion and appropriate drainage may be required.

5. Complex fistulas may be treated with ligation of the intersphincteric fistula tract (LIFT). Grade of Recommendation: No recommendation.

Treatment of Perianal Fistula Associated with Crohn's Disease

1. Asymptomatic fistulas in patients with Crohn's disease do not require surgical treatment. Grade of Recommendation: Strong recommendation based on low-quality evidence 1C.
Anal fistulas in patients with perianal Crohn's disease may be secondary to either Crohn's disease or cryptoglandular origin. Irrespective of etiology, patients with asymptomatic fistulas and no signs of local sepsis require no surgical intervention. These fistulas may remain dormant for an extended period of time; therefore, patients need not be subjected to the morbidity of operative intervention.
2. Symptomatic simple low Crohn's fistulas may be treated by fistulotomy. Grade of Recommendation: Strong recommendation based on low-quality evidence 1C.
Fistulotomy is safe and effective in low-lying simple fistulas involving no or minimal external anal sphincter. Given the chronicity of the

disease and high frequency of disease relapse, maximum preservation of sphincter function is essential. Thus, before embarking on any fistulotomy, surgeons should consider all relevant patient factors, in particular, the extent of anorectal disease, sphincter status and continence, rectal compliance, presence of active proctitis, previous anorectal operations, and stool consistency.

3. Complex Crohn's fistulas may be well palliated with long-term draining setons. Grade of Recommendation: Strong recommendation based on low-quality evidence 1C.
4. Complex Crohn's fistulas may be treated with advancement flap closure if the rectal mucosa is grossly normal. Grade of Recommendation: Weak recommendation based on low-quality evidence 2C.
Endorectal and anodermal advancement flaps may also be used in complex Crohn's fistulas in select patients without active proctitis.
5. Complex Crohn's fistulas may require permanent diversion or proctectomy for uncontrollable symptoms. Grade of Recommendation: Strong recommendation based on low-quality evidence 1C.
A small percentage of patients with extensive and aggressive disease that is uncontrolled by medical management and long-term seton placement may require diversion or proctectomy to control perianal sepsis.

Definitions:

The Grading of Recommendation, Assessment, Development, and Evaluation (GRADE) System–Grading Recommendations^a

	Description	Benefit versus Risk and Burdens	Methodological Quality of Supporting Evidence	Implications
1A	Strong recommendation, high-quality evidence	Benefits clearly outweigh risk and burdens or vice versa	RCTs without important limitations or overwhelming evidence from observational studies	Strong recommendation, can apply to most patients in most circumstances without reservation
1B	Strong recommendation, moderate-quality evidence	Benefits clearly outweigh risk and burdens or vice versa	RCTs with important limitations (inconsistent results, methodologic flaws, indirect, or imprecise) or exceptionally strong evidence from observational studies	Strong recommendation, can apply to most patients in most circumstances without reservation
1C	Strong recommendation, low- or very-low-quality evidence	Benefits clearly outweigh risk and burdens or vice versa	Observational studies or case series	Strong recommendation but may change when higher quality evidence becomes available
2A	Weak recommendation, high-quality evidence	Benefits closely balanced with risks and burdens	RCTs without important limitations or overwhelming evidence from observational studies	Weak recommendation, best action may differ depending on circumstances or patients' or societal values
2B	Weak recommendations, moderate-quality evidence	Benefits closely balanced with risks and burdens	RCTs with important limitations (inconsistent results, methodologic flaws, indirect, or imprecise) or exceptionally strong evidence from observational studies	Weak recommendation, best action may differ depending on circumstances or patients' or societal values
2C	Weak recommendation, low- or very-low-quality evidence	Uncertainty in the estimates of benefits, risks and burden; benefits, risk and burden may be closely balanced	Observational studies or case series	Very weak recommendations; other alternatives may be equally reasonable

RCT = randomized controlled trial

^aAdapted from Guyatt G, Guterma D, Baumann MH, et al. Grading strength of recommendations and quality of evidence in clinical guidelines: report from an American College of Chest Physicians Task Force. Chest. 2006;129:174–181.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Perianal abscess and fistula-in-ano

Guideline Category

Diagnosis

Evaluation

Management

Treatment

Clinical Specialty

Colon and Rectal Surgery

Family Practice

Gastroenterology

Internal Medicine

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Patients

Physician Assistants

Physicians

Guideline Objective(s)

To provide practice parameters on the evaluation and management of perianal abscess and fistula-in-ano

Target Population

Patients with perianal abscess and fistula-in-ano

Interventions and Practices Considered

Assessment

1. Disease-specific patient history
2. Physical examination
3. Fistulography
4. Endoanal ultrasound
5. Computed tomography (CT)
6. Magnetic resonance imaging (MRI)

Treatment of Perianal Abscess

1. Incision and drainage
2. Antibiotics

Treatment of Fistula-in-Ano (Simple, Complex, and Associated with Crohn's Disease)

1. Fistulotomy (with or without incision and drainage or marsupialization)
2. Debridement and fibrin glue injection
3. Anal fistula plug
4. Endorectal advancement flap closure
5. Seton use and/or staged fistulotomy
6. Ligation of intersphincteric fistula tract

Treatment of Crohn's Fistulas

1. Fistulotomy
2. Long-term draining setons
3. Advancement flap closures
4. Permanent diversion or proctectomy

Major Outcomes Considered

- Accuracy of diagnostic tests
- Success and failure rates of treatments
- Healing rates and times
- Recurrence rate
- Infection rate
- Proctectomy rates
- Morbidity associated with treatment, including incontinence

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

An organized search of MEDLINE, PubMed, EMBASE, and the Cochrane Database of Collected Reviews was performed through February 2010. Key word combinations included abscess, fistula, fistula-in-ano, anal, rectal, perianal, perineal, rectovaginal, anovaginal, seton, fistula plug,

fibrin glue, advancement flap, and Crohn's disease. Directed searches of the embedded references from the primary articles were also performed in selected circumstances. Primary authors reviewed all English language manuscripts and studies of adults.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

See the "Rating Scheme for the Strength of the Recommendations" field, below.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Recommendations were formulated by the primary authors and reviewed by the entire committee. The final grade of recommendation was performed using the Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) system (see the "Rating Scheme for the Strength of Recommendations" field) and reviewed by the entire Standards Committee.

Rating Scheme for the Strength of the Recommendations

The Grading of Recommendation, Assessment, Development, and Evaluation (GRADE) System—Grading Recommendations^a

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	evidence Description	Benefit versus Risk and Burdens	Methodological Quality of Supporting Evidence	Implications
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Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Not stated

Description of Method of Guideline Validation

Not applicable

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate treatment and management of perianal abscess and fistula-in-ano

Potential Harms

- Postoperative alterations in continence are reported in 0% to 73% of patients who undergo fistulotomy for simple anal fistula. Limited data have shown that fistulectomy, in which the tract is resected, is associated with longer healing times, larger defects, and a higher risk of incontinence, although recurrence rates are similar when compared with fistulotomy.
- The utility of fistulotomy in conjunction with incision and drainage of an anorectal abscess remains controversial. The surgeon should weigh the possible decreased recurrence rate in light of the potential increased risk of continence disturbances.
- Simple low fistulas have a decreased rate of healing with fibrin glue compared with fistulotomy.
- Recurrence; mild or moderate incontinence; and decreases in resting and squeeze pressures on postoperative manometry with endoanal flap advancement for complex anal fistula disease
- Changes in continence range from 0% to 54% with patients undergoing 2-staged seton procedures or cutting setons. Incontinence to flatus is seen more often than liquid or solid stool incontinence. Finally, in sepsis secondary to fistula disease that is recalcitrant to other methods, diversion and appropriate drainage may be required.
- Mild incontinence rates of 6% to 12% have been reported in patients undergoing fistulotomy for symptomatic simple low Crohn's fistulas. Wound healing in this patient population may be delayed by 3 to 6 months.
- Recurrent sepsis occurs in 20% to 40% of patients with long-term draining setons, with approximately 8% to 13% of patients experiencing some degree of fecal soilage.
- Recurrence rates increase over time with extended follow-up for advancement flap closure.

Qualifying Statements

Qualifying Statements

- These guidelines are inclusive, and not prescriptive. Their purpose is to provide information on which decisions can be made, rather than dictate a specific form of treatment.
- It should be recognized that these guidelines should not be deemed inclusive of all proper methods of care or exclusive of methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the propriety of any specific procedure must be made by the physician in light of all the circumstances presented by the individual patient.
- Because no single technique is appropriate for the treatment of all fistulas-in-ano, treatment must be directed by the etiology and anatomy of the fistula, degree of symptoms, patient comorbidities, and the surgeon's experience. One should keep in mind the progressive tradeoff between the extent of operative sphincter division, postoperative healing rates, and functional compromise.
- The practice parameters set forth in this document have been developed from sources believed to be reliable. The American Society of Colon and Rectal Surgeons makes no warranty, guarantee, or representation whatsoever as to the absolute validity or sufficiency of any parameter included in this document, and the Society assumes no responsibility for the use of the material contained.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1996 (revised 2011 Dec)

Guideline Developer(s)

American Society of Colon and Rectal Surgeons - Medical Specialty Society

Source(s) of Funding

American Society of Colon and Rectal Surgeons

Guideline Committee

Standards Practice Task Force of the American Society of Colon and Rectal Surgeons

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Financial Disclosures/Conflicts of Interest

Not stated

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Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the [American Society of Colon and Rectal Surgeons \(ASCRS\) Web site](#) .

Print copies: Available from the ASCRS, 85 W. Algonquin Road, Suite 550, Arlington Heights, Illinois 60005.

Availability of Companion Documents

None available

Patient Resources

The following is available:

- Anal abscess/fistula. 2008. Available from the [American Society of Colon and Rectal Surgeons Web site](#) .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

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